State of New Jersey
Department of Labor
DIVISION OF WORKERS' COMPENSATION
PO BOX 381
Trenton, New Jersey 08625-0381

ANSWER TO APPLICATION FOR REVIEW OR MODIFICATION OF FORMAL AWARD

C.P. NO. _____

D.O. _____

PETITIONER

SOCIAL SECURITY NUMBER

NAME

ADDRESS (Including County)

VS

RESPONDENT

NAME

ADDRESS (including County)

ATTORNEY FOR RESPONDENT

❑ NEW JERSEY REGISTRATION NUMBER ❑ SSN ❑ FEDERAL EMPLOYER ID NUMBER

NAME

ADDRESS

TELEPHONE (Area Code)

INSURANCE CARRIER

NAME (indicate if Not Covered or self-insured)
NJ REG. OR FEIN

ADDRESS

CARRIER'S CLAIM FILE NUMBER

TO THE DIVISION OF WORKERS' COMPENSATION: _____

in answer to the Application for Review or Modification respondent respectfully states:

TEMPORARY DISABILITY WAS PAID FROM _____ TO _____

for a total of _____ weeks, _____ day's at $ _____ per week, totaling $ _____

PERMANENT DISABILITY WAS PAID FROM _____ TO _____

for a total of _____ weeks, at $ _____ per week, totaling $ _____

The date of the last compensation payment was _____ . The date of the last authorized treatment was _____

The factual, legal and medical reasons for denying the application are as follows:

❑ Demand is hereby made for answers to standard occupational disease interrogatories.

❑ Demand is hereby made for all records of medical treatment, examinations and diagnostic studies.

I certify that the foregoing statements made by me are true to the best of my knowledge, information and belief.

_____ _____

Attorney for Respondent *Date*